

County Case ID # _____

West Nile Case Investigation Short Form

Utah Department of Health, Office of Epidemiology

State Case ID # _____
(For state use only)

Instructions:

1. Complete West Nile Case Investigation Form for all probable or confirmed cases of West Nile virus infection (see case definitions below).
2. List county case ID number (i.e., NETSS ID number)
3. Share information gathered with the Environmental Health division of your local health department.
4. Fax page 4 of investigation form to your local mosquito abatement district (go to www.umaa.org for local contact info).
Inform the patient: Page four (4) asks questions related to the patient seeing or being bit by a mosquito at home, work, or recreation sites. This information will be faxed to the mosquito abatement districts for follow up in the specified areas.
5. Fax completed form to the Utah Department of Health, Office of Epidemiology (801-538-9923).

West Nile Virus Case Definitions:

West Nile Fever

-Confirmed

A Clinically compatible case **plus one** of the following:

1. 4-fold or greater increase in antibody to WNV in paired serum
2. Isolation of WNV from or demonstration of specific WN viral antigen or genomic sequences in tissue, blood, CSF or other body fluid
3. WNV specific IgM antibodies demonstrated in serum and confirmed in the same or later specimen (most commonly used test)

-Probable

Clinically compatible illness with WNV specific antibodies detected by antibody-capture enzyme

West Nile Meningitis and Encephalitis

-Confirmed

Febrile illness with clinically compatible neurological presentation
plus one of the following:

1. 4-fold or greater increase in antibody to WNV in paired serum or CSF
2. Isolation of WNV from or demonstration of specific WN viral antigen or genomic sequences in tissue, blood, CSF or other body fluid
3. IgM antibody to WNV in CSF

-Probable

Febrile illness with clinically compatible neurological presentation
plus one of the following:

1. Serum IgM antibody to WNV
2. Elevated IgG antibody to WNV in a convalescent phase serum

Patient name: _____

Parent or Contact Person: _____

Address/Apt: _____

City: _____ County: _____ Zip Code: _____

Telephone: (H) _____ (W) _____ (Other) _____

Birth Date: ____/____/____ Age: _____ Sex: M F

Race: White Black Asian/Pacific Islander Native American Unknown Other _____
Ethnicity: Hispanic Non-Hispanic

Occupation: _____

Date of onset of symptoms: ____/____/____

Please describe patient symptoms (check if experienced symptom):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Fever (____°) | <input type="checkbox"/> Rash | <input type="checkbox"/> Headache | <input type="checkbox"/> Paralysis or Paresis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Coma |
| <input type="checkbox"/> Lymphadenopathy | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Altered Level of Consciousness |
| <input type="checkbox"/> Meningismus | <input type="checkbox"/> Other, Describe _____ | | |

Please indicate if laboratory testing has been requested for West Nile Virus from:

Acute Serum (< 8 days since symptom onset)

- ☐ Total WBC count: _____
lymph: _____ PMN/neut: _____
- ☐ WNV antibodies (date: ____/____/____)
(IgM: _____ IgG: _____)

Convalescent serum (2-4 weeks after acute)

- ☐ WNV antibodies (date: ____/____/____)
(lab: _____)

CSF (date: ____/____/____)

- ☐ WNV antibodies (IgM: _____ IgG: _____)
- ☐ WBC count: _____
- ☐ Protein: _____

Other Tests (eg: latex panel results)

Laboratory name: _____ Phone: _____

Attending Physician: _____ Phone: _____

Initial Report Status: Confirmed Probable Suspect Not a case Unknown

Presentation of Illness (check all that apply):

- ☐ Meningitis ☐ Encephalitis ☐ **West Nile Fever** ☐ Acute Flaccid Paralysis
- ☐ Unknown ☐ Other _____

Died: Yes No Unknown If Yes, Date of Death: ____/____/____

Hospitalized: Yes No Unknown Name of Hospital: _____
Phone: _____

Date of Hospital Admission: ____/____/____ Total Number of days: _____

Reported by: _____ Phone Number: _____
 Informant: _____
 Relationship to Patient: _____

Does the patient have a history of vaccination or disease for the following:

- ☐ Yellow Fever
☐ Japanese Encephalitis
☐ Dengue Fever
☐ St. Louis Encephalitis
☐ Other Encephalitis Describe: _____ (use p.6 if needed)

Did the patient give blood within the past 6 weeks: Yes No Unknown

If yes, Institution's name: _____

Date of donation: ____ / ____ / ____

MODE OF TRANSMISSION

Did the patient have a transfusion in the 20 days prior to onset of symptoms: Yes No Unknown

If yes, Institution's name: _____

Date of transfusion: ____ / ____ / ____

Has patient had a transplant within the 4 weeks prior to onset: Yes No Unknown

If yes, Institution's name: _____

Date of transplant: ____ / ____ / ____

Is patient pregnant: Yes No Unknown Due Date: ____ / ____ / ____

Obstetricians: _____ Hospital: _____

Is patient breastfeeding or being breastfed: Yes No Unknown Duration: _____

Did patient have workplace exposure (needle stick, laceration, etc.): Yes No Unknown

TRAVEL HISTORY (for the two weeks prior to onset of symptoms)

Has patient traveled **OUT OF CITY**: Yes (provide address) No Unknown

 (Street number) (City) (State) (Zip code)

Dates of Travel ____ / ____ / ____ to ____ / ____ / ____

Is there an open or standing water source at this location? ☐ yes ☐ no ☐ unk

If yes, please describe (e.g. pond, stream, pool, etc):

Time of Day Outdoors (circle all that apply): Dawn Day Dusk Night

Do you remember being bitten by mosquitoes? ☐ yes ☐ no

Has the patient traveled **OUT OF STATE**: Yes (provide address) No Unknown

 (Street number) (City) (State) (Zip code)

Dates of Travel ____ / ____ / ____ to ____ / ____ / ____

Is there an open or standing water source at this location? ☐ yes ☐ no ☐ unk

If yes, please describe (e.g. pond, stream, pool, etc):

Time of Day Outdoors (circle all that apply): Dawn Day Dusk Night

Do you remember being bitten by mosquitoes? ☐ yes ☐ no ☐ unk

Has the patient traveled **OUT OF COUNTRY**: Yes (provide location) No Unknown

Location: _____

Dates of Travel ____ / ____ / ____ to ____ / ____ / ____

Is there an open or standing water source at this location? ☐ yes ☐ no ☐ unk

If yes, please describe (e.g. pond, stream, pool, etc):

Time of Day Outdoors (circle all that apply): Dawn Day Dusk Night

Do you remember being bitten by mosquitoes? ☐ yes ☐ no ☐ unk

Mosquito Abatement Information**HOME**

Home address: _____

(Street number)

(City)

(State)

(Zip code)

For the two weeks prior to onset of symptoms, please answer the following related to **HOME**:

1. Is there an open or standing water source at this location?
- ☐
- yes
- ☐
- no
- ☐
- unk

If yes, please describe (e.g. pond, stream, pool, etc):

2. Were you bitten by mosquitoes?

If yes, please indicate time of day (circle all that apply): Dawn Day Dusk Night

WORK

Work address: _____

(Street number)

(City)

(State) (Zip code)

For the two weeks prior to onset of symptoms, please answer the following related to **WORK**:

1. Is there an open or standing water source at this location?
- ☐
- yes
- ☐
- no
- ☐
- unk

If yes, please describe (e.g. pond, stream, pool, etc):

2. Were you bitten by mosquitoes?

If yes, please indicate time of day (circle all that apply): Dawn Day Dusk Night

RECREATIONPlease list all recreational places visited by the patient in the city for the **2 weeks** prior to onset:

1. _____
2. _____
3. _____
4. _____

Thinking about these places, please answer the following questions:

1. Is there an open or standing water source at this location?
- ☐
- yes
- ☐
- no
- ☐
- unk

If yes, please describe (e.g. pond, stream, pool, etc), and indicate which travel location(s) this pertains to: _____

2. Were you bitten by mosquitoes?

If yes, please indicate time of day (circle all that apply): Dawn Day Dusk Night

Final Checklist

- 1) Report to Utah Department of Health, Office of Epidemiology
Office (801) 538-6191
Fax (801) 538-9923
After Hours Pager 1-888-EPI-UTAH (1-888-374-8824)
- 2) Fax page 5 of investigation form to your local mosquito abatement district
(go to www.umaa.org for local contact info)
- 3) Give any information on standing water to Environmental Health at your local health department for follow up.
- 4) Arrange for convalescent serum to be drawn if not already done
- 5) Final status- Confirmed Probable Suspect Not a case Unknown